

## LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Fermi-2										DOCKET NUMBER (2) 0 5 0 0 0 3 4 1										PAGE (3) 1 OF 4					
TITLE (4) Failure to Meet Sampling Requirements While Exhaust Monitor Was Inoperable																									
EVENT DATE (5)			LER NUMBER (6)				REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)															
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES			DOCKET NUMBER(S)													
0	6	0	4	3	5	8	5	-	0	2	0	-	0	0	0	6	2	7	8	5	0	5	0	0	0
OPERATING MODE (9) 4		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 6 (Check one or more of the following) (11)										73.71(b)													
POWER LEVEL (10) 0 0 0		20.402(b)				20.406(a)				80.73(a)(2)(iv)			73.71(a)												
		20.406(a)(1)(i)				80.38(a)(1)				80.73(a)(2)(v)			OTHER (Specify in Abstract below and in Text, NRC Form 386A)												
		20.406(a)(1)(ii)				80.38(a)(2)				80.73(a)(2)(vi)															
		20.406(a)(1)(iii)				X 80.73(a)(2)(i)				80.73(a)(2)(vii)(A)															
		20.406(a)(1)(iv)				80.73(a)(2)(ii)				80.73(a)(2)(vii)(B)															
		20.406(a)(1)(v)				80.73(a)(2)(iii)				80.73(a)(2)(viii)															
LICENSEE CONTACT FOR THIS LER (12)												TELEPHONE NUMBER													
NAME A.E. Wegele, Compliance Engineer												AREA CODE 3 1 3 5 8 6 - 5 3 1 3													
COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)																									
CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPDs	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPDs	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPDs	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPDs						
X	I	L	P	R	I	N	T	E	0	7	0	N													
SUPPLEMENTAL REPORT EXPECTED (14)																									
YES (If yes, complete EXPECTED SUBMISSION DATE)												X NO		EXPECTED SUBMISSION DATE (15)		MONTH	DAY	YEAR							
ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)																									

At approximately 0230 hours on June 4, 1985, with the plant in operational condition 4, prior to initial criticality, it was determined that grab samples of the Reactor Building ventilation effluent had not been taken within 8 hours of the failure of the Reactor Building ventilation effluent radiation monitor. This did not comply with Actions 121 and 122 of Table 3.3.7.12-1 which apply when the number of operable effluent radiation monitoring channels is less than the minimum required by Fermi-2 Technical Specification 3.3.7.12.b.

The root cause of the event was determined to be personnel error. The Control Room Nuclear Supervising Operator (NSO) on duty when the control terminal for the radiation monitor became inoperable failed to document his instructions to the Chemistry Department for verifying operability of the effluent radiation monitors. Later shifts were not informed of the agreement between Operations and Chemistry to split responsibilities for verifying these monitors, nor was there an entry in the NSO log. Personnel have been counseled to document such instructions in the future. In addition, the event has been discussed with Operations personnel and will be highlighted by a memo placed in the required reading program.

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S PDR

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## LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

APPROVED OMB NO. 3150-0104  
EXPIRES 8/31/86

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
Fermi-2	05000341	85	020	00	02	OF	04

TEXT (If more space is required, use additional NRC Form 308A's) (17)

At approximately 0230 hours on June 4, 1985, with the plant in operational condition 4, prior to initial criticality, it was determined that grab samples and iodine and particulate samples of the Reactor Building ventilation effluent had not been taken within 8 hours of the failure of the Reactor Building ventilation effluent radiation monitor. This did not comply with the requirements of Actions 121 and 122 of Table 3.3.7.12-1 which apply when the number of operable effluent radiation monitoring channels is less than the minimum required by Fermi-2 Technical Specification 3.3.7.12.b.

The root cause of the event was determined to be personnel error. The Control Room Nuclear Supervising Operator on duty when the control terminal for the radiation monitor became inoperable failed to document his instructions to the Chemistry Department for verifying operability of the effluent radiation monitors. Later shifts were not informed of the agreement between Operations and Chemistry to split responsibilities for verifying these monitors, nor was there an entry in the NSO log. Personnel have been counseled to document such instructions in the future. In addition, the event has been discussed with Operations personnel and will be highlighted by a memo placed in the urgent required reading program.

On June 3, 1985, at the beginning of the day shift (0730-1600 hours), the Control Room NSO noted that the Control Terminal (CT-2B) for the effluent radiation monitoring system was malfunctioning. This terminal allows remote monitoring and operation of the SPING (Stationary Particulate, Iodine, and Noble Gas) monitor. A repair order (PN-21) was written on June 2 when problems with the terminal were first noted. The Control Room NSO informed the Nuclear Shift Supervisor (NSS) of the status of the CT-2B terminal and requested that Chemistry personnel perform a visual inspection of all SPING units to verify that they were operating. This visual inspection was completed by 0750 hours and all SPING units were found to be operating properly.

The NSS instructed the NSO to have the visual inspection repeated at two hour intervals, since the status of the SPING's could not be determined while the CT-2B terminal in the Control Room was inoperable. At 1820 the Control Room NSO contacted the Chemistry Lab and arranged for Chemistry personnel to inspect the SPING's on the Radwaste Building HVAC exhaust, Turbine Building HVAC exhaust, Service Building HVAC exhaust, and Onsite Storage Building HVAC exhaust. The NSO and Chemistry agreed that Operations personnel would inspect the SPING's on the Reactor Building HVAC exhaust and the Standby Gas Treatment System. This agreement was not recorded in the NSO's log and the NSS was unaware of

## LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

APPROVED OMB NO. 3150-0104

EXPIRES 8/31/85

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		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
Fermi-2	05000341	85	020	00	03	OF	04

TEXT (If more space is required, use additional NRC Form 368A's) (17)

the specific arrangements. The NSS assumed that the Chemistry section was inspecting all of the SPING's.

At approximately 1000 hours and 1200 hours, Chemistry personnel checked the status of the RW, TB, SB, and OSSB SPING's. Operations checked the RB and SGTS SPING's. All units were found to be operating normally. Chemistry continued its verification of the SPINGs assigned to it, however, Operations did not repeat the inspection of its two assigned SPINGs at 1430 hours. The Control Room NSO did not dispatch an operator to check the SPINGs. During his turnover to the next shift, the Control Room NSO verbally communicated the inspection arrangements to the oncoming NSO. Questioned after the reportable event was discovered, the relieving NSO did not recall being told that Operations was performing the inspections of the Reactor Building and the SGTS SPINGs. Instead, he recalled believing that Chemistry was inspecting all of the SPINGs, based on instructions from the NSS and statements in the shift relief report written by the NSS's. For this reason, the Reactor Building and the Radwaste Building SPINGs were not inspected during the evening shift of June 3, 1985.

Soon after the start of the night shift (2330 hours, June 3 to 0730 hours, June 4), Operations learned from a Chemistry Technician that Chemistry was not checking the RB and SGTS SPINGs. The Nuclear Assistant Shift Supervisor (NASS) could not find documentation that Operations was performing these inspections. At 0130 hours, the NSS requested that Chemistry check the RB and SGTS SPING's. At 0200 hours, a Chemistry Technician found the RB SPING was tripped. He inspected the unit and, finding nothing wrong with the unit, restarted it. At 0205 hours, he informed the NSS of what he had found.

Later that day, at 0855 hours, Chemistry personnel obtained data from the RB SPING's microprocessor which indicated that the unit had tripped between 1230 and 1300 hours on June 3. Therefore, the monitor had been inoperable from then until 0200 on June 4, approximately 13 hours total. During this period, the plant was in operating condition 4, prior to initial criticality, and there were no radioactive gases in the reactor building. Thus the potential for unmonitored releases was negligible and the safety consequences of this event were minimal. However, when the Reactor Building HVAC exhaust monitor tripped, the plant entered the action statement of Technical Specification 3.3.7.12.b. Action statements 121, 122 and 123 of Table 3.3.7.12-1 permit releases to continue provided grab samples are taken every eight (8) hours, and auxiliary sampling equipment is used, as required, and flow is estimated every four (4) hours. The NSS was unaware that the monitor had tripped and did not meet these action requirements.

## LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

APPROVED OMB NO. 3150-0104  
EXPIRES 8/31/85

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (8)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
Fermi-2	0 5 0 0 0 3 4 1	8 5	— 0 2 0	— 0 0 0	4	OF	0 4

TEXT (If more space is required, use additional NRC Form 305A's) (17)

The cause of this event was the failure of the day shift NSO to record his instructions to Chemistry in his logbook and to inform his NSS that Operations was performing the inspections of the RB and SGTS SPINGs. This event has been discussed with the NSO involved. The importance of properly communicating information and documenting information through complete and thorough log entries will be discussed with all licensed operators in their requalification program. This will be emphasized in a memo to be placed in their required reading. In addition, this LER will be included in the operator's required reading and will be discussed with the other licensed personnel during requalification training.



**Detroit  
Edison**

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June 27, 1985  
NP-85-702

U. S. Nuclear Regulatory Commission  
Attention: Document Control Desk  
Washington, D.C. 20555

Gentlemen:

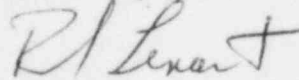
Reference: Fermi 2  
NRC Docket No. 50-341  
NRC Operating License No. NPF-33

Subject: Transmittal of Licensee  
Event Report 85-020

Please find enclosed LER No. 85-020-00, dated June 27, 1985, for a reportable event which occurred on June 4, 1985. As indicated below, a copy of this LER is being sent to the Region III office.

If you have any questions, please contact us.

Sincerely,



R. S. Lenart  
Superintendent  
Nuclear Production

Enclosure: NRC Forms 366, 366A

cc: Mr. P.M. Byron  
Mr. M.D. Lynch

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